Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $1,668.42 for date of service 03/20/01.

   b. The request was received on 02/26/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution dated 03/29/02
   b. HCFA 1450/UB 92
   c. Example EOB(s) from other carriers
   d. EOB(s)
   e. Medical Records
   f. Additional Information received on 04/02/02
   g. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60/Initial response date 03/01/02
   b. HCFA 1450/UB92
   c. EOB
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (4), the Division forwarded a copy of the requestor's additional documentation to the carrier on 04/04/02. The respondent did not respond to the additional documentation. Their initial response is reflected in Exhibit II of the Commission's case file.

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: The requestor states in the correspondence dated 03/29/02 that, "We are appealing the amount disallowed on the above mention [sic] claims. These charges are for **FACILITY FEES**, not professional fees…. We feel that … should reimburse us more appropriately as $2236.00 does not cover our cost to perform this surgery. We feel that our medical services fees are fair and reasonable…. Our facility fees are fair and reasonable because our methodology is to bill according to the supplies, medication, equipment, operating room and recovery room time that was used during the surgery…. has unfairly reduced our bill when other workers' compensation carriers have established that our charges are fair and reasonable because they are paying 85%-100% of our billed charges. Enclosed are examples of bills for the same type procedure of other patients and their insurance companies interpretation of fair and reasonable…"

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 03/20/01.

2. The provider billed $3,904.42 for disputed date of service, 03/20/01.

3. The carrier paid the provider $2,236.00 for date of service, 03/20/01.

4. The amount in dispute for the date of service is $1,668.42.

5. The carrier denied additional payment for date of service 02/01/01 by denial code, "F – Fee Guidelines MAR Reduction" and "THE ATTACHED BILL WAS RETURNED TO…FOR REVIEW FOR ACCURACY. IT APPEARS THAT THIS BILL WAS PROCESSED CORRECTLY AND THEREFORE NO ADDITIONAL ALLOWANCE WILL BE MADE." Even though the carrier denied the billed charges by "fee guideline", there is no MAR for ambulatory surgical centers for facility fee. The provider has accepted the denial as "fair and reasonable" per their letter requesting medical dispute resolution, their letter to the carrier for request for re-consideration, and the explanation on their Table of Disputed Services. The Medical Review Division's decision will be rendered based on the "fair and reasonable" denial code. No other EOB(s) or medical audits were noted.

6. The services provided by the provider include such items as anesthesia and lab services, pharmaceutical products, medical and surgical supplies, sterile supplies and EKG.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgical center. Commission Rule 134.401 (a) (4) states ASC(s) "…shall be reimbursed at a fair and reasonable rate…"

Texas Labor Code Section 413.011 (b) states, "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

The Medical Fee Guidelines General Instructions (VI) discuss that if a MAR value has not been established for a CPT code, reimbursement shall be, "…at the fair and reasonable rate."

The provider submitted additional reimbursement data (EOBs from various carriers) in an attempt to demonstrate payments of fair and reasonable documentation for treatment of an injured individual of an equivalent standard of living in their geographical area. In light of recent SOAH decisions, showing what other carriers have paid an ASC is not evidence of effective medical cost control and is not evidence of amounts paid on behalf of managed care patients of ASC's or on behalf of other non-workers' compensation patients with an equivalent standard of living. The provider's documentation failed to meet the criteria of 413.011 (b).

Because there is no current fee guideline for ASC(s), the health care provider has the burden to prove that the fees paid by the carrier were not fair and reasonable. The provider submitted EOB(s) from other carriers, but the provider failed to meet the criteria of 413.011 (b). Therefore, no reimbursement is recommended.

The above Findings and Decision are hereby issued this 29th day of May 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm